

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH - COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin R.I.D.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin R.I.D. 2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Dorming Creek</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>More</u>	(Middle)	(Last) <u>Cropper</u>
4. DATE OF DEATH	(Month) <u>Jan.</u>	(Day) <u>3</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>married</u>	8. DATE OF BIRTH <u>Mar. 18, 1873</u>
9. AGE last birthday <u>77 yrs.</u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	11. BIRTHPLACE (State or foreign country) <u>Berlin Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Charles Cropper</u>	14. MOTHER'S MAIDEN NAME <u>Dexter Millspan</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>
16. SOCIAL SECURITY No. <u>no</u>	17. INFORMANT AND ADDRESS <u>Mrs. Mott Cropper Berlin Md R.I.D.</u>	18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Carcinoma of bladder</u>		<u>1 year</u>	
Antecedent cause(s) (b) <u>181X 52b</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>Sept 14 50</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of bladder</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 3</u> , 19 <u>51</u> , to <u>Jan 3</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>Jan 3</u> , 19 <u>51</u> , and that death occurred at <u>5 A.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Thomas H. D. Cropper</u>		DATE SIGNED <u>Jan 5 1951</u>	
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF <u>1/5/51</u>	NAME OF CEMETERY OR CREMATORY <u>Buckingham</u>	LOCATION (City, town, or county) (State) <u>Berlin Md</u>
DATE REC'D BY LOCAL REG. <u>1-5-51</u>	REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>	24. FUNERAL DIRECTOR <u>Anne D. Burboys</u>	ADDRESS <u>Berlin Md</u>

100105



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1013 355

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Maple Berlin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Maple Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Eileen</u>	(Middle)	(Last) <u>Dennis</u>
4. DATE OF DEATH	(Month) <u>Jan</u>	(Day) <u>13</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1862</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>88</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Berlin Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Dennis</u>		14. MOTHER'S MAIDEN NAME <u>Grace Costman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Addie Lunnell Berlin Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Uremia sec to nephrosclerosis c

INTERVAL BETWEEN ONSET AND DEATH

10 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized atherosclerosis10 yrs(c) Senility

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

2nd Degree Burns both legs - (Hot Water Bottle)2 weeks

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 10 Jan, 1951, to 13 Jan, 1951, that I last saw the deceasedalive on 13 Jan, 1951, and that death occurred at 9:54 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

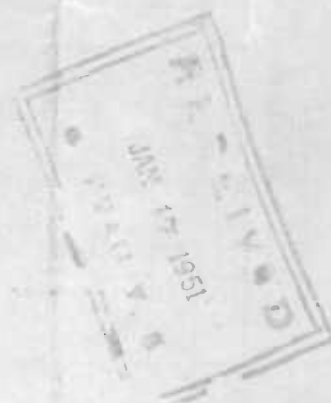
Herman L. Robbins M.D. 5 Bay St. Berlin, Md1/14/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>1/16/51</u>	<u>St. Pauls (Col)</u>	<u>Berlin</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1/15/51</u>	<u>Helen F. Hayward</u>	<u>Anna A. Burboys</u>	<u>Berlin Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR Berlin		LENGTH OF STAY (In this place) Abt. 5 mos.		CITY (If outside corporate limits, write RURAL and give nearest town) OR Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS at home				STREET ADDRESS (If rural, give location) 38 S. Eden St.	
3. NAME OF DECEASED (Type or Print) Aatie		(First) (Middle) (Last)		4. DATE OF DEATH January 21 1951	
5. SEX Female		6. COLOR OR RACE AA		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) "1 GOW	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY House Work		8. DATE OF BIRTH About 1895	
13. FATHER'S NAME Aaron Funnell		14. MOTHER'S MAIDEN NAME Sallie Funnell		9. AGE last birthday About 56 yrs.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no no		16. SOCIAL SECURITY No. no		11. BIRTHPLACE (State or foreign country) Berlin, Worcester County, Md.	
				12. CITIZEN OF WHAT COUNTRY? USA	
				17. INFORMANT AND ADDRESS Rufus Aaron Funnell, Berlin, Md. Rt. 3	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **Acute Myocarditis**

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last(b) **Hypertension**(c) **Chronic myocarditis**

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.**Arthritis**

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?
Yes ☐ No ☐TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not While
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Oct. 1, 1950**, to **1/21/51**, 19....., that I last saw the deceased
alive on **1/18/51**, 19....., and that death occurred at **2A** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-23-51**Helen F. Hayward****James B. Dashiell****Salisbury Md.**

720826

WW 1-29-51

MARGIN RESERVED FOR BINDING

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1015

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Whaleyville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Whaleyville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>R 7 D</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Betty</u> (Middle) <u>Jean</u> (Last) <u>Hicks</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 29 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>—</u>	8. DATE OF BIRTH <u>1/22/51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE last birthday <u>0</u> yrs. <u>0</u> months <u>2</u> days
11. BIRTHPLACE (State or foreign country) <u>Whaleyville MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert D. Hicks</u>		14. MOTHER'S MAIDEN NAME <u>Shirley Temple Barclay</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Robert Hicks Whaleyville MD</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

755x Immediate cause

(a) Asphyxia, sec & Aspiration

1610

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Clft Palate, congenital, deformity

(c)

INTERVAL BETWEEN ONSET AND DEATH

4 hours1 1/2 days11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
OF INJURY				

22. I hereby certify that I attended the deceased from 24 Jan., 1951, to 24 Jan., 1951, that I last saw the deceasedalive on 24 Jan., 1951, and that death occurred at 1:25 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Stamand. Rablin M.D. Box 16, Berlin, Md 1/24/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1/25/51</u>	<u>Evergreen</u>	<u>Berlin</u>	<u>MD</u>

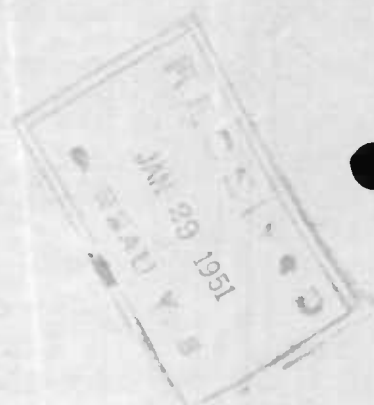
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>1-25-51</u>	<u>Helen F. Hayward</u>	<u>Anne D. Burbanck</u>	<u>Berlin Md.</u>

401281141405

MARGIN RESERVED FOR BINDING

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VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1016

CERTIFICATE OF DEATH

Reg. Dist. No. 351

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sum Hill</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sum Hill</u>	
TOWN <u>Sum Hill</u>		TOWN <u>Sum Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Collins St.</u>		STREET ADDRESS (If rural, give location) <u>Collins St.</u>	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>Holloway</u> (Last)		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1878</u>
9. AGE last birthday <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Off bearing of Sum Hill</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Don't know</u>		14. MOTHER'S MAIDEN NAME <u>Don't know</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>16</u>	
17. INFORMANT AND ADDRESS <u>Ella Holloway Sum Hill, Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

7952 Immediate cause (a) Sudden death

199 Antecedent cause(s) (b) Unknown

(c) 374

INTERVAL BETWEEN ONSET AND DEATH
2 or 3 daysII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
Yes ☐ No ☐

21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from after death, 1951, to 1/12/51, that I last saw the deceased alive on 1/12/51, and that death occurred at 11:25 m. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan. 14/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	LOCATION (City, town, or county) <u>Sum Hill, Md</u>	(State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>1/13/51</u>	REGISTRAR'S SIGNATURE <u>LeRoy Smith</u>	24. FUNERAL DIRECTOR <u>Wiley Edmunds</u>	ADDRESS <u>Sum Hill, Md</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

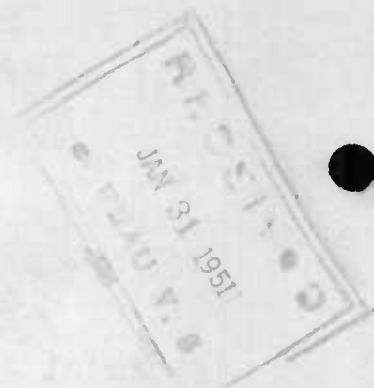
1017
 Reg. Dist. No. 357

1. PLACE OF DEATH COUNTY Worcester		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Worcester	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural, Snow Hill		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural, Snow Hill	
HOSPITAL OR INSTITUTION OR STREET ADDRESS RFD # 1		STREET ADDRESS (If rural give location) RFD # 1	
3. NAME OF DECEASED (Type or Print) Sadie (First) GRACE (Middle) HOPE (Last)		4. DATE OF DEATH Jan 27, 1951 (Month) (Day) (Year)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 1874 (Year) 77 yrs. (Age last birthday)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE last birthday 77 yrs.
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Tom J. Colona		14. MOTHER'S MAIDEN NAME Mary Berry	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT George Bonnaville Jr., Snow Hill Md			

18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause Acute bronchitis			3 or 4 days
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 260X 61 Chronic bronchitis			years
(c) Diabetes			years
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Had a fall in Dec 1950			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR? Injury occurred While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE Dr. H. E. Antomius - Dep. Med. Ex.		DATE SIGNED Pocomoke City, Md 1/28/51	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 1/29/51	
NAME OF CEMETERY OR CREMATORY Parksley Cemetery		LOCATION (City, town, or county) (State) Parksley, Va.	
DATE REC'D BY LOCAL REG. 1/29/51		24. FUNERAL DIRECTOR Henry H. Watson, Pocomoke City Md	

MARGIN RESERVED FOR BINDING

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2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Berlin</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Berlin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Rt D St. Martins.</u>	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>Wilary</u> (Middle) <u>Hudson</u> (Last)		4. DATE OF DEATH <u>Jan. 24</u> (Month) <u>24</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Single</u>	8. DATE OF BIRTH <u>Mar. 29, 1858</u>
9. AGE last birthday <u>92</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Shoreville, Md</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>William Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Jane Shades.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>no.</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Elizabeth Mumford Berlin Md</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Arteriosclerotic Heart disease

Antecedent cause(s)

(b) General Arteriosclerosis(c) Senility

INTERVAL BETWEEN ONSET AND DEATH

3 years3 year

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June, 1949, to Jan. 23, 1951, that I last saw the deceasedalive on Jan. 23, 1951, and that death occurred at Jan. 23, 1951, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

T. J. O'Donnell M.D.Berlin, Md.Jan. 25-1951

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1/26/51</u>	<u>Evergreen</u>	<u>Berlin</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1-25-51</u>	<u>Helem F Hayward</u>	<u>Anna A. Burdop</u>	<u>Berlin Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

100105



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>at home - Route #3</u>		STREET ADDRESS (If rural, give location) <u>Route #3</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle) <u>Stewart</u>	(Last) <u>Hudson</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>aa</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>12-8-1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	9. AGE last birthday <u>73 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Berlin Worcester Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Albert Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Annie - Hudson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Henrietta Hudson - Berlin Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Anuscarica, complete w/ Chronic Myocarditis 1/2 yr.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) du & Generalized Atherosclerosis with(c) Diabetes Mellitus

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Achitis, Syphilis, severe, general

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Nut While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 11, 1950, to Jan 11, 1957, that I last saw the deceased alive on Jan 11, 1957, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Harman A. Robbins M.D. Berlin, Md.

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1-14-57</u>	NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>	LOCATION (City, town, or county) <u>Berlin, Worcester Co. Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>1-13-57</u>	REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>	24. FUNERAL DIRECTOR <u>James B. Washell, Salisbury, Md.</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1022

1. PLACE OF DEATH- COUNTY Worcester MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Worcester	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Pocomoke City, Md.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN 411 Bonnaville, Ave.	
HOSPITAL OR INSTITUTE OR STREET ADDRESS Home		STREET ADDRESS (If rural, give location) Pocomoke City, Md.	
3. NAME OF DECEASED (Type or Print)	(First) George (Middle) Henry (Last) Long	4. DATE OF DEATH	(Month) Jan. (Day) 3 (Year) 1951
5. SEX Male	6. COLOR OR RACE Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 15, 1873 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher		10b. KIND OF BUSINESS OR INDUSTRY Contractor	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Robin Long		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Annie Downing - Pocomoke City, Md.		17. INFORMANT AND ADDRESS Annie Downing - Pocomoke City, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

574X Immediate cause

(a) **Interstitial Nephritis**

Antecedent cause(s)

131a

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

18 months

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 20, 1949, to Jan 5th, 1951, that I last saw the deceased alive on Jan 2nd, 1951, and that death occurred at 10:45 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	1/7/51	Unionville cemetery	Pocomoke City, Md.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
Jan. 5, 1951	Anne E. White	Buckner M. West	Salisbury, Md.	

970 246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1023

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pocomoke City</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pocomoke City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rural</u>		STREET ADDRESS <u>Rural</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>JOHN</u> (Middle) <u>THOMAS</u> (Last) <u>MERRILL</u>		4. DATE OF DEATH Jan 4, 1951 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug 12, 1865</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	9. AGE last birthday <u>85</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Thomas Merrill</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Burton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Hargis Merrill, Pocomoke City, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cancer, Rectal</u>			<u>3 Months</u>
154X Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
46d II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>Oct 2, 1950</u> , to <u>Jan 4, 1951</u> , that I last saw the deceased alive on <u>Jan 4, 1951</u> , and that death occurred at <u>455a.m.</u> from the causes and on the date stated above.					
SIGNATURE <u>Charles W. Trader, A.B., M.D.</u>		ADDRESS <u>Pocomoke City Md</u>		DATE SIGNED <u>Jan. 5, 1951</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>Jan 6, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Bethany Meth Cemetery</u>	
LOCATION (City, town, or county) <u>Pocomoke City, Md.</u>		(State) <u>Md.</u>			
DATE REC'D BY LOCAL REG. <u>Jan. 5 1951</u>		REGISTRAR'S SIGNATURE <u>Anne E. White</u>		24. FUNERAL DIRECTOR <u>Henry H. Watson, Pocomoke City, Md.</u>	

100105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1024

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH- COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>85 yrs.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> TOWN STREET ADDRESS (If rural, give location) <u>West St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Cornelia</u> (First) (Middle) (Last) <u>Mills</u>		4. DATE OF DEATH <u>Jan 12 1951</u> (Month) (Day) (Year)			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>Sept 15, 1865</u>	9. AGE last birthday <u>85 yrs.</u>	10. If under 1 year Months Days Hours If under 24 hrs. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Berlin Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Johnson Dennis</u>		14. MOTHER'S MAIDEN NAME <u>Jane Shockley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>		17. INFORMANT AND ADDRESS <u>Dr. Ernest Mills Berlin Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Chronic Myocarditis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chr. Brights with Asthma

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 daysII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.Age

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan, 1950, to Jan 12, 1951, that I last saw the deceasedalive on Jan 12, 1951, and that death occurred at 6 P M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Crement</u>	<u>1/14/51</u>	<u>Riverside</u>	<u>Berlin</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1/14/51</u>	<u>Helen F Hayward</u>	<u>Anna A. Bunyan</u>	<u>Berlin Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 855

1020

1. PLACE OF DEATH COUNTY <i>Worcester</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Worcester</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Worcester</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Worcester</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <i>No number</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Annie</i> (Middle) <i>Florence</i> (Last) <i>Powell</i>	4. DATE OF DEATH (Month) <i>Jan</i> (Day) <i>12</i> (Year) <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>Sept 16, 1873</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>77</i> yrs. <i>7</i> Months <i>4</i> Days
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<i>Delaware</i>		<i>U.S.A.</i>	
13. FATHER'S NAME <i>J. William Collins</i>		14. MOTHER'S MAIDEN NAME <i>Phyllis Davis</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
(If yes, give war or dates of service)		<i>17. INFORMANT AND ADDRESS</i> <i>Benton Powell Worcester, Md.</i>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Bronchopneumonia*

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Mysocarditis

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from *Jan 7*, 19*57*, to *Jan 12*, 19*57*, that I last saw the deceased alive on *Jan 12*, 19*57*, and that death occurred at *5:00 P.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>buried</i>	<i>Jan 15, 1957</i>	<i>State Cemetery</i>	<i>Worcester</i>	<i>Md.</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		
<i>1-15-57</i>	<i>Helen F Hayward</i>	<i>M. Pasha Watson Worcester, Md.</i>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 19 1961
B. A. JONES

Evidence for change
of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1025

CERTIFICATE OF DEATH

Reg. Dist. No. 355

FILM No. G 130 JAN 16 1951

1. PLACE OF DEATH- COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route #1</u>		MARYLAND LENGTH OF STAY (in this place) <u>all life</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> TOWN STREET ADDRESS (If rural, give location) <u>Route #1</u>	
3. NAME OF DECEASED (Type or Print) <u>Lillie</u> (First) <u>Alice</u> (Middle) <u>Purnell</u> (Last)		4. DATE OF DEATH <u>1</u> - <u>2</u> - <u>1951</u> (Month) (Day) (Year)		5. SEX <u>Female</u>	
6. COLOR OR RACE <u>A A</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>		8. DATE OF BIRTH <u>12-19-24</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory</u>		9. AGE last birthday <u>26</u> yrs. <u>0</u> Months <u>13</u> Days	
11. BIRTHPLACE (State or foreign country) <u>Berlin, Worcester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles Purnell</u>	
14. MOTHER'S MAIDEN NAME <u>Blanche Prideman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-14-4793</u>	
17. INFORMANT AND ADDRESS <u>Charles E. Purnell, Berlin, Md.</u>					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pelvic Peritonitis, sec to Abortion 3 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Leptisemia - Possible acute Yellow

(c) Atrophy of Liver - Pres. 3 mos. Duration

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

Chronic Hepatitis - following pregnancy 2 yrs

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 3/24/50, 1950, to 2 Jan, 1951, that I last saw the deceased alive on 2 Jan, 1951, and that death occurred at 4:30 P m., from the causes and on the date stated above.

SIGNATURE:

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>1-6-51</u>		NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		LOCATION (City, town, or county) (State) <u>Berlin, Worcester Co., Md.</u>	
DATE REC'D BY LOCAL REG. <u>1-5-51</u>		REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>		FUNERAL DIRECTOR <u>James B. Barfield</u>		ADDRESS <u>Salisbury, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

690408

RECEIVED
JUN 9 1961
RENU A. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Whaleysville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Whaleysville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Rural</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary Ellen Duellen</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>Jan. 27</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>July 26-1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>82</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>Peter Murray</u>		14. MOTHER'S MAIDEN NAME <u>Alanta Gault</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mary Eva McCabe</u> <u>Whaleysville md.</u>		12. CITIZEN OF WHAT COUNTRY?	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Acute Myocardial Failure</u>	<u>1 day</u>
Antecedent cause(s)	(b) <u>red Chronic Degenerative Myocarditis</u>	<u>6 yrs</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>due to Atherosclerosis, generalized</u>	<u>10 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 27, 1951, to Jan. 27, 1951, that I last saw the deceased alive on Jan. 27, 1951, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) <u>Heinrich R. H. M. D. & B. S. L. Barlow, Md.</u>	ADDRESS <u>1/28/51</u>	DATE SIGNED
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>1/30/51</u>	NAME OF CEMETERY OR CREMATORY <u>Ebenezer Churchyard near Seebysville, Del.</u>
DATE REC'D BY LOCAL REG. <u>1-29-51</u>	REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>	24. FUNERAL DIRECTOR <u>Henry J. Watson, Pocomoke City, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1026

1. PLACE OF DEATH - COUNTY Worcester		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland COUNTY Worcester	
CITY (If outside corporate limits, write RURAL and give nearest town) Berlin		CITY (If outside corporate limits, write RURAL and give nearest town) Berlin	
TOWN Berlin		TOWN Berlin	
HOSPITAL OR INSTITUTION OR STREET ADDRESS at home		STREET ADDRESS (If rural, give location) flower St.	
3. NAME OF DECEASED (Type or Print)	(First) George	(Middle) E.	(Last) Robbins
4. DATE OF DEATH	(Month) Jan.	(Day) 29	(Year) 1951
5. SEX Male	6. COLOR OR RACE A A	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 6-11-1860
9. AGE last birthday 90 yrs.		10. BIRTHPLACE (State or foreign country) Berlin, Worcester Co., Md.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arnold Robbins		14. MOTHER'S MAIDEN NAME Rhoda --- Robbins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY No. none	
17. INFORMANT AND ADDRESS Miss Laura Funnell, Berlin, Md.			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

592.x Immediate cause (a) **Chr. myocarditis**

131b Antecedent cause(s) (b) **Chr. nephritis**

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

3 weeks

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. **Age**

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?		
OF	While at Not While			
INJURY	m. Work <input type="checkbox"/> At work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from **Jan. 10., 1951.** to **Jan. 29, 1951.**, that I last saw the deceased alive on **Jan. 28., 1951.**, and that death occurred at **5 a.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

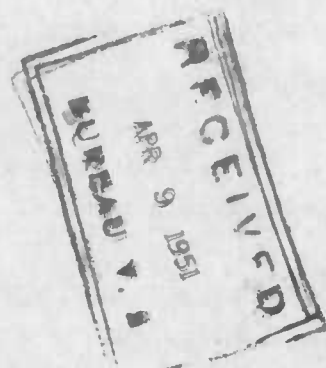
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2-2-51	Evergreen Cemetery	Berlin, Worcester Co., Md.	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
2-2-51	Helen F. Hayward	James B. Dashiell	Salisbury, Md.	

790836

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1027 351

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Snow Hill</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Snow Hill</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Nellie</u> (First) <u>Robins</u> (Middle) <u>Robins</u> (Last)		4. DATE OF DEATH <u>Jan. 31</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 14 - 1885</u> <u>69</u> yrs. (Month) (Day) (Year)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
13. FATHER'S NAME <u>John Robins</u>		14. MOTHER'S MAIDEN NAME <u>Betty Duffy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. L. R. Jones Snow Hill, Md</u>		12. CITIZEN OF WHAT COUNTRY?	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Cerebral Vascular Accident</u>		<u>7 days</u>
Antecedent cause(s)	(b) <u>Hypertensive Cardiovascular disease</u>		<u>10 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE		INJURY		<u>Snow Hill Worcester Md.</u>	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Not While		HOW DID INJURY OCCUR?	
OF INJURY		m. Work <input type="checkbox"/> At work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from Jan 23, 1951, to Jan 31, 1951, that I last saw the deceased alive on Jan 30, 1951, and that death occurred at 10:30 A m., from the causes and on the date stated above.

SIGNATURE <u>Betty L. Mar.</u> (Degree or title)		ADDRESS <u>Snow Hill, Md</u>		DATE SIGNED <u>2-1-51</u>	
23. BURIAL, CREMATION (Specify)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Baptist</u>		<u>Snow Hill Md</u>	
DATE REC'D BY LOCAL REG. <u>2/1/51</u>		REGISTRAR'S SIGNATURE <u>Betty Smith</u>		24. FUNERAL DIRECTOR <u>Way E. Dammis</u> ADDRESS <u>Snow Hill, Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
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INVESTIGATION
U. S. DEPT. OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1028 355

1. PLACE OF DEATH - COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>William St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Jesse</u> (Middle) <u>Jarvis</u> (Last) <u>Taylor</u>	4. DATE OF DEATH	(Month) <u>Jan.</u> (Day) <u>4</u> (Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>Sept. 19, 1898</u>
9. AGE last birthday <u>52</u> yrs.		10. AGE last birthday If under 1 year Months <u>3</u> Days <u>15</u> Hours <u>15</u> Mins. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>	
11. BIRTHPLACE (State or foreign country) <u>Ocean City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jesse B. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>May Jarvis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u> (If yes, give war or dates of service) <u>no.</u>		16. SOCIAL SECURITY No. <u>no.</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Jesse J. Taylor Berlin Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Chronic pyelitis</u>		<u>3 yrs.</u>
Antecedent cause(s) (b) <u>Rheumatic fever</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Obesity</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 1947, 19....., to day of death, 19....., that I last saw the deceased alive on 1-4-51, 19....., and that death occurred at 12:12 P. m., from the causes and on the date stated above.

SIGNATURE Frank Lewis M.D. ADDRESS Wellsford Maryland DATE SIGNED 1-5-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/6/51</u>	NAME OF CEMETERY OR CREMATORY <u>Burkington</u>	LOCATION (City, town, or county) <u>Berlin</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>1-6-51</u>	REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>	24. FUNERAL DIRECTOR <u>Anna A. Burboys</u>	ADDRESS <u>Berlin Md.</u>	

290667

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1029

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ocean City</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ocean City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>310 Maryland Ave.</u>		STREET ADDRESS <u>310 Maryland Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>BENNETT</u> (First) <u>REBECCA</u> (Middle) <u>WADDILL</u> (Last)		4. DATE OF DEATH <u>Jan 29, 1951</u> (Month) (Day) (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec 5, 1870</u>
9. AGE last birthday <u>80</u> yrs.		10. If under 1 year 1 year 11. If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>R. S. Eckles</u>		14. MOTHER'S MAIDEN NAME <u>Bennett E. Tucker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Robert M. Waddill, Pocomoke, Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
442x Immediate cause (a) <u>Osteomalacia Etiology under.</u>				<u>1 yr.</u>	
Antecedent cause(s) (b) <u>Hypertensive, calcareous cardiac condition</u>				<u>2 yrs.</u>	
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Psychological fractures both legs, 1st clavicle & humerus</u>				<u>3 mos</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Oct, 1950, to 29 Dec, 1950, that I last saw the deceased alive on 29 Dec, 1950, and that death occurred at 8 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>		<u>Jan 31, 1951</u>		<u>Baptist Cemetery</u>		<u>Pocomoke, Md.</u>			
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
<u>Jan 31, 1951</u>		<u>Helen J. Hayward</u>		<u>Henry H Watson, Pocomoke, Md.</u>					

MARGIN RESERVED FOR BINDING

VS. A15

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